

MENTAL CAPACITY ACT AND ITS RELEVANCE TO WOUND CARE

Patient consent is an absolute requirement before a health care professional can carry out any care or intervention for a patient. Most of the time this will not be problematic, but there will be occasions when clinicians encounter patients who refuse recommended care and treatment. There will also be the need to provide care in situations where patients are unable to give consent. The Mental Capacity Act (2005) (Department for Constitutional Affairs, 2005) provides a legal framework for protecting patients who lack capacity to give consent and the professionals who care for them. This article will outline the key principles of the Act and the capacity assessment. A case study will illustrate the mental capacity assessment in practice.

In 1994, a patient (referred to here as Mr C) was diagnosed with a serious and life-threatening gangrene in his foot. His surgeon recommended amputation, however, Mr C refused to give consent. Mr C had a diagnosis of schizophrenia and was a long-term patient in a high security psychiatric hospital in UK. This decision caused a conflict between Mr C's psychiatrist and his surgeon. His psychiatrist believed he was unable to make a valid choice because of his delusional beliefs, which included believing he was a 'great doctor.' She felt to respect his wishes would lead to his unnecessary death. His surgeon believed he had the right not to consent to the surgery, and that the central issue was whether Mr C had the mental capacity to make a choice, not whether the doctors agreed with his decision.

The case went to the High Court and the judge determined that Mr C did indeed have capacity to

make an informed decision, having demonstrated an understanding of his situation, the ability to remember and believe the medical information received and an ability to weigh up the options.

This proved to be a landmark case in establishing patients' capacity to decide what happens to their bodies. The concept of capacity was eventually given statutory force in the Mental Capacity Act (MCA) (2005) (Department for Constitutional Affairs [DCA], 2005).

This article will outline the key principles of the MCA and discuss how it can be relevant when providing wound care. A case study will be used to illustrate one example.

The Key Principles of the Mental Capacity Act (2005)

The MCA came into force in 2007, and relates to all persons over the age of 16 in England and Wales.

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The MCA is primarily about setting criteria for establishing an individual's capacity to make decisions. It also makes provision for people to appoint someone to act on their behalf in the event of them not having capacity in the future, through a Lasting Power of Attorney or Independent Mental Capacity Advocate (IMCA). Without this legal agreement, no family or friend has the power to make decisions on behalf of someone else, and treatment is then decided by the person providing that treatment, following the principles of 'best interests' (McHale, 2009).

The five key principles of the MCA are outlined in *Box 1*. There are two stages to the assessment to determine mental capacity. The first is to ask: "Does the person have an impairment of, or disturbance in, the functioning of the mind or brain (this may be temporary or permanent)?" This could include diagnoses of dementia, brain injury, learning disability, or temporary states such as delirium or intoxication.

If the answer to this question is 'no' then the person is deemed to have capacity to make decisions. If the impairment is likely to be temporary then if possible the decision needing to be made should be left until capacity returns. Every assistance should be given to help the person make the decision (e.g. communication aids, written or visual information, time of day if this affects mental state). If the answer is 'yes', however, then a second question needs to be asked: "Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?"

The fact that a person has an impairment or disturbance of the mind or brain does not

Box 1. The five main principles of the Mental Capacity Act 2005.

Always assume the patient has mental capacity unless it is proven otherwise by undertaking a Mental Capacity Assessment

Before deciding a patient lacks capacity, ensure all practical steps have been taken to support the patient with the assessment

An unwise decision does not mean that the patient lacks capacity to make a decision

Any decision made on behalf of a patient lacking mental capacity must be made in their best interests

Always consider whether there is a least restrictive option when making any best interests decision.

automatically mean they lack capacity. Four key questions need to be asked to establish capacity.

- ▶ Can the person understand and absorb basic information relevant to the decision to be made?
- ▶ Can the person retain the information long enough to process it?
- ▶ Can the person weigh up the advantages and disadvantages?
- ▶ Can the person communicate his or her decision?

It is important to understand that the mental capacity assessment is undertaken for a specific decision and is not a 'blanket-cover' assessment for all decisions. People may fluctuate in their decision making ability, or be able to make decisions about some aspects of care or daily life, but not others. The assessment must, therefore, be carried out at the time the decision needs to be made and is the responsibility of the person providing the care at the time (Bingham, 2012)

Consent

Consent is required before any clinician can touch a patient (Department of Health, 2009)

and intervention without valid consent may constitute a civil or criminal offence of battery (Ford, 2010). Consent can be given in a number of ways (verbal, written or implied) and can be withdrawn at any time (Ford, 2010; Guy, 2010). All clinicians should follow their organisation's consent policies and procedures, as well as any professional guidance. For consent to be valid, it is necessary that the person has the mental capacity to give consent. It is in cases where there is doubt over a patient's capacity that a mental capacity assessment should be initiated.

Provided a person has capacity, he or she has the right to provide or withhold consent from treatment or care. Decisions to refuse treatment or care are often difficult for clinicians to understand or accept (Beldon, 2014), and can create conflicts of interest in the nurse-patient relationship. Patients have the right to make decisions which may be seen as unwise by a clinician. It is essential, however, that the patient has been provided with all relevant information to help them reach their decision, including benefits and risks, and potential consequences of each option, in a way that is accessible

for them to understand. This must be documented in the patient's records, with details of any conversations and discussions provided (The Nursing and Midwifery Council, 2008).

MCA and wound care

Any intervention to provide wound care will require consent from the patient (e.g. changing dressings, applying compression bandaging or hosiery, skin inspection as part of pressure ulcer prevention, or provision of pressure relieving equipment). Nurses may often encounter conflicting views or behaviour by patients when attempting to deliver 'best practice' care. For example, patients sometimes decline bandaging, or pressure relieving equipment, or remove their dressings. Such patients can sometimes be labelled 'non-compliant', which carries negative or judgemental connotations.

'Compliance' is a term that reflects the extent to which patients are seen to follow medical advice and, therefore, non-compliance suggests the problem lies with the patient (Anderson, 2013; McNichol, 2014). Concordance is a term advocated by the Royal Pharmaceutical Society to reflect an emphasis more on partnership and negotiation, which takes into account the patient's perspective, and where there may need to be an agreement to differ at times (Anderson, 2013).

This is often a source of frustration to both patients and nurses. Nurses are anxious to provide 'best practice' care in line with evidence and guidelines to achieve the best outcomes for patients in terms of wound healing or pressure ulcer avoidance. Additionally, organisations are monitored and audited on outcomes (such as venous leg ulcer healing rates, or pressure ulcer incidence rates),

which may be linked with financial penalties if targets are not achieved. Therefore, patients who refuse recommended care and treatment can cause nurses anxiety if harm occurs as a result of the patient's decision not to accept care, or outcomes are not met.

Patients must be provided with sufficient information, including all options, benefits and risks, and implications of their choices, in a way they can understand. Reasons for refusal of care or treatment should be explored with the patient. For example, patients may be unable to tolerate compression bandaging

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due to uncontrolled pain, or they may decline pressure relieving equipment because of fears of not being able to sleep in a double bed any longer with a partner or spouse.

It may be that during such open discussions, misconceptions can be corrected, or compromises reached. However, if patients have mental capacity then their autonomy must be respected (Bedford and Jones, 2014). Clause 14 of the NMC Code of Conduct (2008) states that: “You must respect and support people's rights to accept or decline treatment and care”. The MCA (2005), therefore, gives protection to clinicians when patients with capacity make decisions that may be detrimental to their health. It is important to ensure a full record of

discussions is documented, and that the decision is reviewed from time to time as patients can change their mind over time as their situation changes or as new information comes to light.

If there is any doubt or uncertainty over a patient's capacity then the two-stage mental capacity assessment must be conducted and documented using the structure outlined in the MCA (Mughal, 2014). Organisations may have their own locally agreed formats for recording this, which should be followed. It is important to be clear which decision the assessment is relating to as patients may have capacity to make some decisions but not others. Capacity may fluctuate and where possible assessment should be delayed until the person regains capacity. If treatment cannot be delayed, then the clinician providing the care needs to make a decision in the person's best interests at that time (Stevens, 2013).

A best interests decision should be made after considering the patient's clinical need, and the benefits and burdens of treatment on their health and life expectancy. It should also involve any parties who know the patient well (e.g. family/close friends/GP) and who would be able to advise on what the patient would most likely want if they could express their wishes, based on their values and belief systems (Griffith, 2006). However, unless there is a legal Lasting Power of Attorney in existence, families do not have any legal right to make decisions on behalf of the person (DCA, 2005; McHale, 2009). The decision must not be based solely on age, appearance, behaviour or condition (Mughal, 2014).

The case study below illustrates how the mental capacity assessment was conducted and documented

in the case of a patient who was refusing pressure relieving equipment.

Case study

Mrs B is a 77-year-old woman with Type 2 diabetes mellitus and a medical history that includes a previous brain tumour, coronary artery bypass graft and a cerebrovascular accident (CVA) with resulting right-sided weakness and expressive dysphasia. She lives alone with twice-daily visits from carers and regular visits from District Nurses (DNs) for pressure area checks and blood tests. She is keen to be independent and struggles to accept that she needs help at times, resulting in a number of falls over a short period, but on each occasion she has refused to go to hospital for X-rays.

The DN was requested to visit when the carer noticed she had a 'sore heel'. On inspection by the DN, she was observed to have a black eschar (unstageable pressure ulcer) on her right heel measuring 3.8 x 2cm and it was tender to touch. Her Waterlow risk assessment score was 20 (very high risk).

Mrs B had recently started sleeping in a chair at night and refused to go to bed. The DN was concerned the heel ulcer had developed as a result of her resting her heel on the floor for support at night while sleeping in a chair and recommended she sleep in her bed on her pressure relieving mattress and have a pressure reducing cushion on her chair. Mrs B refused both the above. The carers were asked to monitor her heels daily, and inform the DN of any change. The DNs also visited twice weekly to monitor the situation. There was concern that Mrs B was at high risk of further pressure area damage and deterioration of the existing heel ulcer without the recommended equipment or interventions, and as

there was concern over her mental capacity to make these choices, a mental capacity assessment was conducted following the structure laid down in the MCA (2005).

The decision

Mrs B has declined the recommendations to go to bed at night and to accept a pressure reducing cushion on her chair.

The Reason for the MCA

As previously mentioned, Mrs B had a CVA several years ago leaving her with a right sided weakness and severe dysphasia. Her verbal communication is significantly impaired. There is reason to be concerned that her decision to refuse recommendations may be associated with a cognitive impact from her CVA. She tends to be unrealistic about her physical limitations, and she will try to do things that put her at risk of falls.

Support to help patient make decision

Written information was provided on the causes and prevention of pressure ulcers to supplement verbal information given by the DN. A photograph was taken of her heel with her consent and shown to her to help her understand the results of pressure on her heel.

Is there an impairment of, or disturbance in, the functioning of the mind or brain?

Yes. Mrs B has had a CVA with subsequent physical and communication difficulties. There is a possibility of some cognitive impairment also.

Is the patient able to understand the information relating to the decision?

Yes. Understanding was evidenced from examples of interactions between the DN and the patient. While she declined equipment, she did agree to recommendations about sitting posture, elevating her legs and 'floating'

the heels. Additionally, there were concerns that she was not taking the correct dosage of anticoagulant medication. Mrs B demonstrated to the DN the dosage she was taking, which was evidence that she could understand and respond to complex verbal requests. Questions were asked in different ways to yield both a 'yes' and a 'no' answer to the same question, and Mrs B was consistent in her responses.

Is the patient able to retain the information long enough to process it?

Yes. Mrs B gave consistent responses to the same question when asked in different ways on different occasions. She also remembered advice on sitting posture and was implementing this.

Is the patient able to weigh up and use the information?

Yes. Although communication was difficult, Mrs B understood that the photograph was of her heel and appeared shocked when she saw it. When it was explained that if the heel got worse she might need to go to hospital she clearly indicated she was not in agreement with this through gestures, limited speech, and her answers to the same question worded differently.

Is the patient able to communicate her decision?

Yes. Although verbal communication was severely limited, Mrs B repeated the same terms, but with different emphasis, which is understood by those who know her well. She could nod and shake her head, and use physical gestures to indicate her desires.

Following the mental capacity assessment, it was felt on balance that Mrs B did have capacity to decline the recommendations being made by the DN. As a result, liaison with the GP, care manager and care agency took place to discuss the risk that remained, and this was then reflected in her care plan for all agencies to follow. She

continued to be monitored closely by her carers and the DNs, and the heel ulcer went on to heal subsequently.

Conclusion

The Mental Capacity Act (2005) provides the legal authority and protection to deliver health and social care where a person lacks capacity and cannot give consent. It also protects the right of people who have capacity to make decisions which may conflict with the recommendations of health and social care professionals.

Any decision by a patient to refuse care or interventions that could prove to be detrimental to their health must be fully explored with the patient and resolution sought. If the patient has full mental capacity then their decision must be respected and all conversations documented in the patient's record.

If there is concern that the patient may not have the capacity to make an informed choice, then a mental capacity assessment should be conducted and documented. This should be performed by the health care professional needing to provide the care at the time, and the particular decision needing to be made must be clearly defined.

If after assessment the patient is considered not to have capacity, a decision about the delivery of care or treatment needs to be made in their best interests, using the principles set out in the MCA

(2005). If in any doubt about a patient's ability to give valid consent to treatment, then advice should be sought from a more senior colleague. Many NHS organisations will also have an Adult Safeguarding Lead who will be able to give advice and support **WE**

References

- Anderson I (2013) Understanding compliance and concordance among people with leg ulcers. *Wound Essentials* 8(2): 71–4
- Bedford S and Jones E (2014) Should practitioners override patient choices? *Nurs Times* 110(41): 15–6
- Beldon P (2014) Conflict in care: Respecting the decision of the individual. *Wounds UK* 10(1): 48–50
- Bingham S (2012) Refusal of treatment and decision-making capacity. *Nurs Ethics* 19(1): 167–72
- Department for Constitutional Affairs (2007) Mental Capacity Act 2005: Code of Practice. DCA, The Stationery Office, London. www.tinyurl.com/MCA2005-code
- Department for Constitutional Affairs (2005) *The Mental Capacity Act 2005*. The Stationery Office, London
- Department of Health (2009) *Reference Guide to Consent for Examination or Treatment* (2nd ed.) The Stationery Office, London

Ford L (2010) Consent and capacity: a guide for district nurses. *Br J Community Nurs* 15(9): 456–60

Griffith R (2006) Making decisions for incapable adults 1: Capacity and best interest. *Br J Community Nurs* 11(3): 119–25

Guy H (2010) Accountability and legal issues in tissue viability nursing. *Nurs Standard* 25(7): 62–7

McHale J (2009) Capacity to consent- health care and adult patients. *Br J Nurs* 18(10) 639–41

McNichol E (2014) Involving patients with leg ulcers in developing innovations in treatment and management strategies. *Br J Community Nurs* 19(Suppl 9): S27–32

Mughal A (2014) Understanding and using the Mental Capacity Act. *Nurs Times* 110(21): 16–8

Nursing and Midwifery Council (2008) *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*. NMC, London.

Re C (Adult: Refusal of Treatment) [1994] 1 WLR 290. <http://theconversation.com/meet-the-man-who-gave-you-the-right-to-say-no-to-your-doctor-22568>

Stevens E (2013) The Mental Capacity Act 2005: considerations for nursing practice. *Nurs Standard* 28(2): 35–9